STATE OF CALIFORNIA

ACCIDENT REPORT
(Other than Motor Vehicle)

STD. 268 (REV. 8-94)

This report should be completed and distributed within 48 hours of the incident. Attach any photos or diagrams.

CONFIDENTIAL--ATTORNEY/CLIENT PRIVILEGED DOCUMENT

This is a CONFIDENTIAL report to provide information for use by legal counsel in the event a claim is filed against the State or its employees. Under no circumstances should information be given to anyone except authorized state officials.

INCIDENT DATE	LOCATION *(Describe specific location on reverse)*	TIME

INJURED PARTY INFORMATION

INJURED PARTY'S NAME *(Last, First, M.I.)*	BIRTH DATE	DRIVER'S LICENSE NUMBER
INJURED PARTY'S MAILING ADDRESS *(Street, City, State, Zip)*	**HOME TELEPHONE NUMBER**	**WORK TELEPHONE NUMBER**
	( )	( )

NATURE AND EXTENT OF APPARENT / CLAIMED INJURY *(Describe incident in detail on reverse.)*

PHOTOGRAPHS TAKEN	IF YES, BY WHOM	FIRST AID GIVEN	IF YES, BY WHOM
☐ YES ☐ NO		☐ YES ☐ NO	

PROPERTY DAMAGE/LOSS INFORMATION

PROPERTY OWNER'S NAME *(Last, First, M.I.)*	HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER
	( )	( )

PROPERTY OWNER'S MAILING ADDRESS *(Street, City, State, Zip)*

NATURE AND EXTENT OF DAMAGE / LOSS *(Describe in detail on reverse of this page)*

WITNESS INFORMATION

NAME *(Last, First, M.I.)*	ADDRESS *(Street, City, State, Zip)*	TELEPHONE NUMBER
1.	WORK	( )
DRIVER'S LICENSE NUMBER:	HOME	( )
2.	WORK	( )
DRIVER'S LICENSE NUMBER:	HOME	( )
3.	WORK	( )
DRIVER'S LICENSE NUMBER:	HOME	( )

REPORTING AGENCY NAME

REPORTING EMPLOYEE'S NAME AND TITLE *(Print or Type)*	TELEPHONE NUMBER
	( )

REPORTING EMPLOYEE'S SIGNATURE

REPORTING EMPLOYEE'S SUPERVISOR'S NAME AND TITLE *(Print or Type)*	TELEPHONE NUMBER
	( )

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COPY--OFFICE OF RISK AND INSURANCE MANAGEMENT, 1325 J STREET, SUITE 1800, SACRAMENTO, CA 95814 (OR IMS D-32)
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STATE OF CALIFORNIA

ACCIDENT REPORT

(Other than Motor Vehicle)

STD. 268 (REV. 8-94) (REVERSE)

USE ADDITIONAL SHEETS AS NECESSARY

DESCRIBE SPECIFIC LOCATION OF THE INCIDENT

DESCRIBE THE INCIDENT IN DETAIL